

**Report to CHESAI on an end of project evaluation - outcomes and impact.**

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## **CONTENTS**

### **1.....Introduction, Approach, Questions and Methods**

- 1.1 Introduction to Report
- 1.2 Approach
- 1.3 Questions
- 1.4 Methods

### **2.....CHESAI: Development, Activities and Reach**

- 2.1 Describing CHESAI
- 2.2 An Evolving Theory of Change
- 2.3 CHESAI Networks and Outcomes: a Graphic Analysis

### **3.....Evaluating CHESAI's Theory of Change from within: from Reach to Outcome and Impact**

- 3.1 Participant Perspectives on ToC
- 3.2 Environment
- 3.3 Trans-nationality and the Global South
- 3.4 Boundary Spanning - Networking across Disciplines and Institutions
- 3.5 CHESAI Tracing Relationships, Ideas and Practices- a graphic analysis

### **4.....Critical perspectives**

- 4.1 A Question of Inclusivity and Inter-disciplinarity
- 4.2 A Question of Articulation and Ambivalence
- 4.3 A Question of Longevity of Intention

### **5.....Conclusions**

## **1. Introduction, Approach, Questions and Methods**

### **1.1 Introduction to Report**

CHESAI (Collaboration for Health Systems Analysis and Innovation), an HPSR hub that engages practitioners and scholars in collegial inquiry and exchange in the Western Cape, across South Africa, across the African continent and further afield, is drawing to a close in its current funded period of operation. While it is hoped and intended that the collaboration continue well into the future, an end-of-project evaluation has been undertaken [1].

This evaluation has sought to generate an account of the outcomes of CHESAI's endeavours over the past four to five years and, where possible, an indication of what longer term impact it has had or contributed to, or is likely to have had or contributed to in the years to come. It focuses especially on the drivers of change within the field of HPSR – that is researchers, teachers and policy makers. In this process, we have sought to -

- trace the story of CHESAI as it unfolded over five years, through its intentions – to grow the field of HPSR through growing and strengthening existing networking initiatives – and reflections on its accomplishments and challenges.
- show its impact, or emerging impact, through three selected cases: the teaching of those it reached; South-South networking, especially through a focused reflection on its reach into Ghana in particular and West Africa in general and; HPSR collegiality in the Western Cape, through the UCT-UWC collaboration in the context of the Western Cape.
- offer an overview of CHESAI's reach through mapping the extent of the various networks it has supported and reached, offering a context for the case studies and a further illustration of its work.

### **1.2 Approach**

This evaluation is intended to serve several purposes at once, including –

- offering an account of what CHESAI has achieved and learnt for sharing with donors, partners and members of the CHESAI community.
- supporting individual, inter and intra-organisational learning for CHESAI participants about the *doing* of collaboration and what it takes to work collaboratively for health systems strengthening.
- the generation of knowledge/research outcomes on selected aspects of CHESAI's work.
- the generation of accessible material and accounts of CHESAI's learning and impact that can be shared with others working in similar ways.

### **1.3 Questions**

Three main questions have run across all areas of the enquiry –

- How has CHESAI impacted on the thinking and doing of the individuals who have been reached by it?
- How has CHESAI impacted on the networks of which it is a part, to which it contributes and that it has contributed to developing (the networked, filigreed character of CHESAI asks for

different ways of seeing its reach and so the networks themselves become 'outcomes' and impacts to be investigated)?

- How has CHESAI contributed to transforming the demographics and discourse around HPSR, especially in its contribution to amplifying a voice from the global South?

#### 1.4 Methods

Methods used have included [2] –

- Reading, reflection and synthesis of the extensive existing CHESAI documentation, including its proposal and reports, reflection sessions held with CHESAI participants, the mid-term evaluation and selected academic publications.
- Two reflective conversations with CHESAI leadership, reflecting on the reach of the network and generation of web analytics that trace the reach of the recently re-launched website.
- Observation of CHESAI activities, including Winter School, a bi-monthly meeting and retreat sessions.
- Interviews with CHESAI contributors and participants. Interviews were held with various CHESAI role-players: a cross section of those at the centre of the initiative, and those at its edges; those with long association and those newer to it; scholars and practitioners; South Africans and non-South Africans. In each we pursued the evaluation's three guiding questions: what are the main ideas that might have been sparked, or partly sparked through, CHESAI involvement? What networks and institutional linkages have been enabled or strengthened through CHESAI involvement? What role might CHESAI involvement have played in amplifying voices from the global South?
- Generation by CHESAI contributors of reflective accounts on the three selected cases: teaching, south-south networking and Western Cape collegiality.
- Utilisation of the qualitative data software suite, NVivo, in order to identify trends and compare the weighting of pertinent themes.

In the next section we look to compare the original proposal, the mid-term evaluation and the final report in order to chart the progress that has been made over the past five years, and to offer some analysis on how progress has been consolidated and on what has worked and why. We then turn to the qualitative portion of the evaluation, which used ethnographic methods to gain an emic understanding of CHESAI from amongst participants themselves, and we reserve the final section of our report to reflect on the areas in which progress may have been slower and offer some reflections as to why this may have been the case.

## **2. CHESAI: Development, Activities and Reach**

### **2.1 Describing CHESAI**

CHESAI was established in 2012 with funding from the Canadian International Development Research Centre (IDRC). It is an implicitly Health Policy and Systems Research (HPSR) embedded initiative, with HPSR being defined in the original CHESAI funding proposal as

“...an emerging field that seeks to understand and improve how societies organize themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes. By nature, it is interdisciplinary, a blend of economics, sociology, anthropology, political science, public health and epidemiology that together draw a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape – and be shaped by – health systems and the broader determinants of health” [3].

As also noted in the original CHESAI proposal,

“...the specific building blocks of any health system encompass: governance, financing, human resources, information systems, medical products, vaccines and technologies, and service delivery (WHO 2007). In addition, health systems encompass the interactions and interrelationships among them and among the various actors involved in the system” [4].

Thus, CHESAI emerged from a very clear consensus that health systems are complex, dynamic organisms, whose various components “overlap and together provide the knowledge base needed to support health system strengthening” [5]. From this platform of understanding, health researchers from the University of Cape Town (UCT) and the University of the Western Cape (UWC) aimed to address the void in HPSR in Lower Income and Middle Income Countries (LIMICs), which had been previously identified by the World Health Organisation (WHO) ‘Task Force on Scaling up Research and Learning on Health Systems,’ which suggested

“...that very little of the increased investment in health systems research in low and middle income countries has trickled down to national organisations and researchers. In 2008, for example, the median grant size for such work in high income countries was nearly thirty times higher than in low and middle income settings (WHO, 2009). Overall, less than 0.02% of total health funding is spent on health systems research in low and middle income countries” [6].

Therefore, the original aims of CHESAI were explicitly listed as follows:

1. Raise the profile of the field – building understanding of the multidisciplinary foundations of HPSR and their contributions in tackling current health policy and systems challenges;
2. Support theoretical and conceptual development – bringing wider social science perspectives, existing empirical work and the tacit knowledge of experienced practitioners to the task of better understanding health policy and health systems, and how to strengthen policy implementation and system performance;
3. Support methodological understanding and development – for example, in relation to new approaches to complex programme evaluation, the use of the case study approach, multiple and mixed method studies, and the processes of action research and reflective inquiry;
4. Develop stimulating research environments in which to nurture researchers at all stages of their career, and especially younger researchers;
5. Develop training programmes for HPS and related research within African and other LIMIC-based universities, that provide the basis for the sustainable and long-term development of capacity in the field (particularly at Master’s and doctoral level through the strengthening of MPH type programmes);
6. Engage and spread knowledge and capacity through LIMIC researcher networks [7].

The most succinct statement of original intent from CHESAI is also to be found in the first proposal. It reads as follows:

“The overall goal of CHESAI is to expand and strengthen the African health policy and systems knowledge base. This goal will be achieved by harnessing and consolidating the health policy and systems expertise at the Universities of Cape Town and the Western Cape in South Africa, developing and applying research approaches and methodologies for this emerging field, and by building wider African communities of practice (of both researchers and practitioners), in close collaboration with colleagues based in other LIMIC countries” [8].

The means by which CHESAI sought to achieve these objectives were listed in the same document:

1. Build an intellectual hub for health policy and systems research, development and innovation in Africa through inter-institutional collaboration in health systems research and teaching between the Schools of Public Health at the Universities of Cape Town and the Western Cape;
  2. Create spaces for critical engagements between researchers and practitioners, aimed at building African communities of practice in health systems strengthening and innovation;
  3. Provide systematic opportunities and environments for deepening the health policy and systems research knowledge and methodological base, particularly for understanding and impacting on complex health and related systems, by:
    - a. thinking creatively;
    - b. supporting research activities;
    - c. talking across disciplinary boundaries;
    - d. synthesizing various forms of knowledge;
    - e. facilitating analytical engagement across existing collaborative projects.
  4. Support African HPSR capacity development through a range of awards to support scholarship and by developing innovative post graduate teaching materials.
  5. Share and disseminate HPSR conceptual and methodological innovations through a range of outputs and communication channels.
- [9]

It is largely against the backdrop of these aims (what can be thought of the first iteration of CHESAI’s Theory of Change) that this evaluation occurs.

Lastly, it bears mentioning that this collaboration between UCT and UWC in the form of CHESAI, does not occur out of the blue, but builds upon a number of pre-existing, concurrent projects. Examples of these projects are as follows:

- CHEPSAA (the Consortium for Health Policy and Systems Analysis in Africa): an initiative which aims to develop African HPS teaching and research capacity through support for curriculum development, staff development and engagement between the research and policy worlds through a network of 7 African and 4 European partners;
  - The DIALHS project (District Innovation and Action Learning for Health Systems): an action research project currently being implemented through collaboration with the Western Cape Provincial Department of Health and the health department of the City of Cape Town, and involving support for and reflection on district health system development;
  - A multi-faceted collaboration around the development of a new South African community care giver policy framework, as part of the broader efforts to strengthen primary health care;
  - The Resilient and Responsive Health Systems (RESYST) consortium, a six year research consortium, which supports research and capacity development across a set of African and Asian groups and countries.
- [10]

CHESAI originally intended to interact with these pre-existing projects in the following ways:

- By contributing to CHEPSAA's development of HPSR teaching materials.
- By drawing on the conceptual and methodological experience of DIALHS (specifically, including the research-health system manager collaboration that underpins it)
- By drawing on the conceptual and methodological experience of the South African community care giver policy framework (specifically, the research-health system manager collaboration that underpins it).
- By drawing on the conceptual and methodological experience of the RESYST project (specifically in terms of its work outside South Africa).

[11]

## 2.2 An Evolving Theory of Change

Instrumental to CHESAI's *modus operandi* is a commitment to a dynamic Theory of Change (ToC). This section of the report is concerned with tracing the evolution of CHESAI's ToC and evaluating the ways in which the ToC responded to emergent challenges between 2012 and 2016.

Notwithstanding the original proposal, CHESAI's aims are clearly articulated throughout their years of operation. Here, for instance, we find them summarily expressed in their call for practitioner sabbaticants in 2012:

"[CHESAI aims] to contribute to expanding and strengthening the health policy and systems knowledge base in Africa through building an intellectual hub for HPSR in Cape Town, South Africa, creating spaces for engagements between researchers and practitioners in South Africa and Africa, and supporting HPSR capacity development and sharing/disseminating new thinking on HPSR with interested stakeholders across Africa" [12].

In five years of practice, CHESAI has honoured their commitment to a dynamic ToC in order to taper their original ideals into practical methods of engagement, learning from experience and adjusting accordingly. In its first year narrative report, CHESAI's aims for field-building in HPSR were broadly consistent with their original aims.

Its specific objectives remained to:

- Build an intellectual hub for health policy and systems research, development and innovation in Africa through inter-institutional collaboration in health systems research and teaching between the Schools of Public Health at the Universities of Cape Town and the Western Cape;
- Create spaces for critical engagements between researchers and practitioners, aimed at building African communities of practice in health systems strengthening and innovation;
- Provide systematic opportunities and environments for deepening the health policy and systems research knowledge and methodological base, particularly for understanding and impacting on complex health and related systems, by: thinking creatively; supporting research activities; talking across disciplinary boundaries; synthesizing various forms of knowledge facilitating analytical engagement across existing collaborative projects.
- Support African HPSR capacity development through a range of awards to support scholarship and by developing innovative post graduate teaching materials. Share and disseminate HPSR conceptual and methodological innovations through a range of outputs and communication channels.

[13]

As can be seen, these aims closely mirror the aims of the original ToC. However, in order to meet their objectives, CHESAI had to be both proactive and adaptable. To give one case in point, after the first round of practitioner sabbaticals in 2013, it was clear that a more structured programme was required if the sabbaticants were going to get the most out of their experience. An immediate change to the programme was brought about, where, in addition to the recruitment and support of four sabbaticants, CHESAI resources were also used to support practitioners and academics to attend UWC Winter School, where they were engaged in focused and highly resourced immersion in HPSR courses with immediate practical application to their home environments [14]. In 2015 and 2016, 49 participants had benefited from the Winter School opportunity, including academics, researchers and public health practitioners.

The formation and sustained existence of the Western Cape HPSR Journal Club, where researchers and practitioners regularly convened to engage in fertile debate of HPSR concepts is another example of a successful intervention that came about as a result of CHESAI's clear ToC and is sustained through its responsiveness and adaptability. In this instance, when invited to adapt the Journal Club, participants have opted to retain its fundamental purpose, membership and style. CHESAI's responsiveness has been shown here in engagement around the topics that are covered, ensuring that they are relevant to the needs and realities of practitioners, and through exploration of the times that Journal Club might meet in order to enable as wide a range of participation as is possible.

We list the other successes of CHESAI during its five years of operation below:

- The creation of a space to support the practitioner/researcher interface through, amongst other things, initiation and maintenance of the Western Cape HPSR Journal Club; creation of practitioner sabbaticals and Winter School bursaries; and continued extension of collegial opportunities to practitioners, where possible.
- The hosting of regular retreats, with the explicit intention of creating a nurturing environment within which members of the local hub can think, reflect, and write in an atmosphere of collegiality, collective reflection and mutual interest in HPSR. Participation at these retreats has also been extended to those members outside of the local CHESAI hub who visit, engage and join it periodically.
- The organisation and hosting of bi-monthly gatherings involving the UCT/UWC hub; a space for collegial enquiry and collective reflection across individual research interests, traditional hierarchies and institutional boundaries.
- The creation of a viable post-doc programme, with an explicit emphasis on further strengthening the practitioner/researcher interface and the global network, encouraging leadership, and nurturing collaborative approaches in the next generation of HPSR scholars.
- The growth of an intercollegiate network across the globe - through drawing visiting experts, post-docs and others to Cape Town, and through maintenance of these relationships (through collaborative research, support to institution building and collaboration in international events).
- 52 Journal papers and book chapters published; 62 in progress or submitted; 29 workshop and conference presentations; 12 organised sessions; 26 posters, orals and multimedia presentations, all touching upon themes pertinent to CHESAI's ToC, namely, 'Theory and Approaches'; 'Southern Voices', 'Southern Capacity and South-South Collaboration in HPSR'; 'Health systems 'software''; 'Governance, Leadership and Policy Implementation'; 'Intersections between Sectors and Systems'; 'People of the health system': 'Community, health workers and users'; or 'Whole system perspectives.'
- Involvement and organisation of the 2014 Global HSR Symposium in Cape Town and participation in the 2016 Global HSR Symposia in Vancouver



- 9 Reports; 12 PhD Studies supported with time and input, 4 of which also with funding; 12 MPH Students supported; 4 new projects catalysed.
- In terms of online reach, out of 13 key publications selected for tracking: 28 868 downloads; 109 citations; 135 tweeters. Also, over five months the new website has had 1419 users - 20% SA, 20% UK, 10% Kenya; 3491 page-views; 77% returning visitors; and downloads of course material via the CHESAI page from 56 countries, in 18 months. Specifically, these downloaded materials were: 'Introduction to Complex Health Systems' – 296 times (minimum); 'Introduction to Health Policy and Systems Research' – 249 times (minimum); and 'Understanding Health Policy' 414 times (approximate).

Through this flexibility in application, while retaining clarity of purpose, CHESAI has managed to open the necessary networks and relationships that hold potential to promote and pursue their approach to HPSR further, both globally and spanning regions all the way to a global level, even beyond the lifetime of CHESAI itself. This is no mean feat.

Within this space that has been created, progress has also been made towards building greater understanding of the interdisciplinarity entailed in HPSR, as well as bringing greater voice to HPSR within public health scholarship. By sidestepping a strictly disciplinary or epidemiological approach, CHESAI has invited both qualitative and quantitative methodologies to bear on the health issues facing Southern Africa and beyond. Whilst the evaluators found that there is room within CHESAI to be even more interdisciplinary, or even trans disciplinary (see Max-Neef 2005), the question of how to include multiple disciplinary voices is clearly one that CHESAI has deeply considered. What is more, the boundary spanning capacity of CHESAI (especially its ability to bridge the fields of research and practice) is particularly apparent and effective.

### 2.3 CHESAI Networks and Outcomes: a Graphic Analysis

One way of conceiving of CHESAI's reach is to see it as part of a range of existing overlapping networked fields that have been grown and strengthened over the years of its existence. While CHESAI exists within already established social and intellectual webs, graphic representation of those that it has been actively involved in helps show where CHESAI opportunities and investments have contributed to strengthening reach and deepening perspective. These are included as part of the evaluation report in a separate document.

In the following section of the evaluation, we draw on interviews and internal documents pertaining to the work of CHESAI, so as to give critical voice to the participants in the programme and to round out the statistical outputs listed above with details of CHESAI as a participatory experience.

# CHESAI: COLLABORATION FOR HEALTH SYSTEMS ANALYSIS AND INNOVATION

## 2012 – 2016 | REACH AND OUTCOMES



### GLOBAL HPSR NETWORK

Promoting HPSR as including: a systems view; inter-disciplinarity; bringing academia, policy makers and practice into collaboration and conversation



### GLOBAL SOUTH CHESAI NETWORK

Strengthening voices from the South to benefit and transform own health systems and global HPSR.



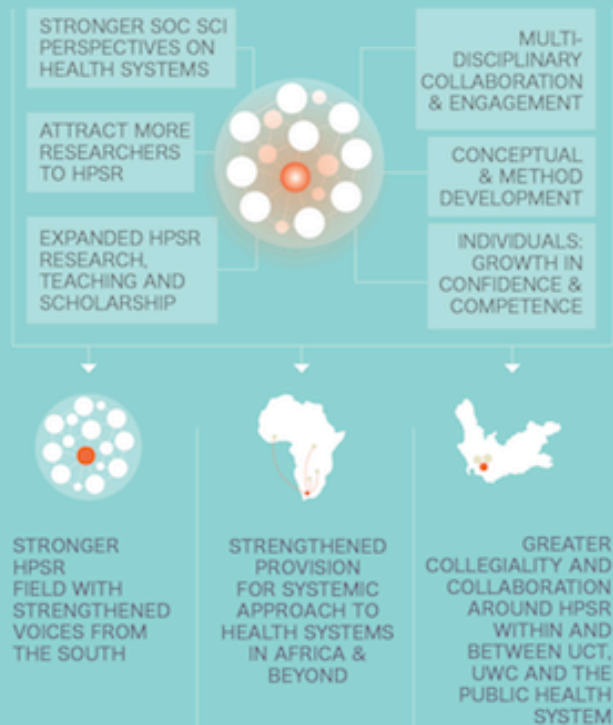
### CHESAI WESTERN CAPE ACADEMIC HUB

Generating collaboration, working from a systems perspective, strengthening bonds through the South and global HPSR.

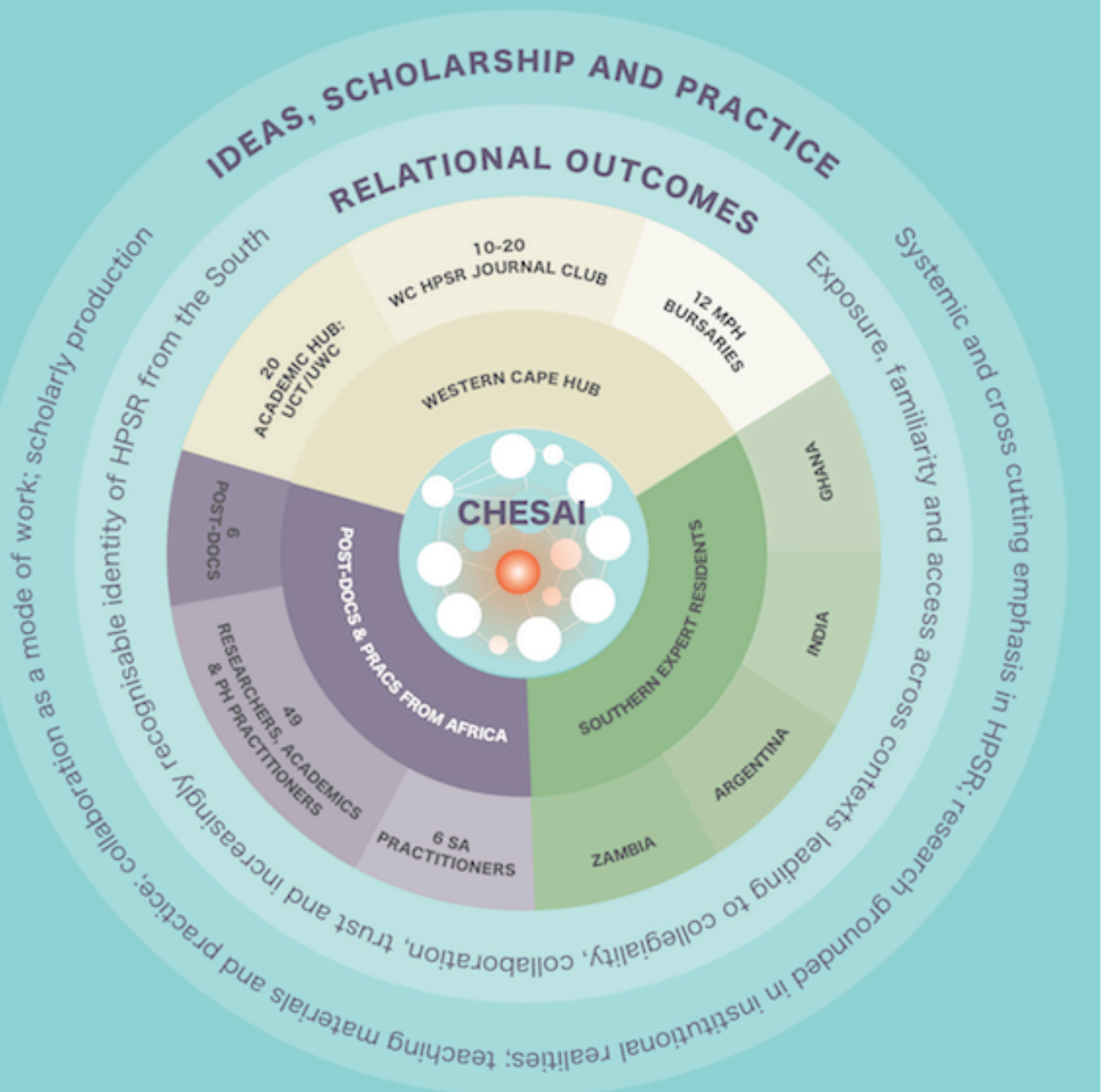
### CHESAI HUB OFFERINGS



### CHESAI NETWORK OUTCOMES



**CHESAI: COLLABORATION FOR HEALTH SYSTEMS ANALYSIS AND INNOVATION**  
 2012 – 2016 | **TRACING RELATIONSHIPS, IDEAS AND PRACTICES**



### **3. Evaluating CHESAI's ToC from within: from Reach to Outcome and Impact**

The degree to which CHESAI might be judged as successful is the degree to which its reach, and creation of opportunities for collaboration across even traditional boundaries, has facilitated outcomes, or impact. The following section of the report synthesises qualitative data collected from interviews and the written reflections of participants in order to offer a more in depth and qualitative dimension to evaluation of CHESAI's work.

During the interviews conducted for the evaluation, and our reading of internal, unpublished reflections, four broad areas of analysis emerged.

- Participants' general perspective on CHESAI's ToC
- The CHESAI environment
- Trans-nationality and the Global South
- Boundary and network spanning across disciplines and institutions

However, within these broad categories, much else was revealed, including; commentary on leadership and guidance; perspectives on CHESAI's operations, research activities and sustainability; and the potential for extending the field of HPSR in the Global south.

#### **3.1 Participant perspectives on ToC**

As demonstrated, CHESAI's ToC was reiterated and adapted throughout its five year period of funded operation. It is, however, worthwhile to reflect briefly on how CHESAI's ToC was interpreted by participants outside of the core group of permanent organisers. To the mind of one participant (whose views on the matter reflected the majority), CHESAI represented "a partnership between the public health departments at the University of Cape Town and the University of the Western Cape, which seek to provide a space for dialogue between Southern institutions and academics, with a focus on capacity building for HPSR [14]". They noted that CHESAI's mode of work, characterised as 'boundary spanning,' is effective at bringing different parts of the world of HPSR together; at working with systems *as systems*; and at developing capabilities to work systemically, further still. They listed CHESAI's activities as including research, capacity building and engagement, with a focus on ensuring rigour and depth in the research and capacity building work, conducted through intercollegiate relationships.

It is a healthy sign that CHESAI's ToC was so plainly understood by a majority of participants. However, it also must be remarked that for some participants, especially in its initial phase, CHESAI's reason for being appeared at times to be "amoebic," "fuzzy," or "nebulous." This was felt to be the case, partly because CHESAI was perceived as 'another' collaborative project between UCT and UWC with little to distinguish it from other collaborations, and partly due to some confusion surrounding the term 'interdisciplinarity.' Macquillan (2016) has noted that this generalised usage of the term 'interdisciplinary' is fairly abundant within HPSR and is certainly not unique to CHESAI. Nonetheless, a more clearly defined iteration of the term might have been beneficial, both for intellectual clarity, and for framing more specifically the types of output that CHESAI is aiming to achieve. For instance, which fields, specifically, are being drawn upon to participate with improving HPSR in the Global South?

There is, naturally, a corollary embedded in creating an interdisciplinary space, and this was picked up by the participant above. Whilst CHESAI did not actively seek to attract clinicians in particular, this could be a group with whom to work – and this participant wondered whether there was

potentially a sense from some doctors that due to CHESAI's social science bias, it was too 'fluffy,' or else seen as a 'luxury' that technically orientated doctors could ill afford when there were lives to be saved. From their perspective, this was not a drawback per se, as they had found that, in their experience, doctors have a tendency to dominate discussion. Nonetheless, it was interesting to note that one potential unintended consequence of CHESAI's inclusivity might be the exclusion of the certain medical doctors who perceive the interdisciplinary approach to be *too* inclusive for their liking. Finally, on the point of interdisciplinarity, this participant remarked that CHESAI's connection with senior management (many of whom are, in fact, medically trained) was, anyway, likely more important than the involvement of clinicians.

In the view of another contributor, CHESAI's concerns have been principally 'technical' or process oriented – in the sense of developing methods and approaches to building trust in the researcher/practitioner interface, as well as growing capacity in HPSR, as distinct from pursuing distinctive 'content' or knowledge outcomes. This contributor, along with others, identified CHESAI's attempt to make instrumental changes to HPSR in Africa in the strong emphasis that the initiative puts on leadership. The attempt to grow a new generation of HPSR thinkers was frequently cited as an important focus of CHESAI, and evidenced in the eyes of those interviewed, in the fact that emergent scholars are installed at UWC's Winter School and given a platform and support to grow as teachers. One participant who had experience of public health in the UK and Africa reflected on a subtle shift in emphasis between what CHESAI was doing and what they had experienced in Europe. In the UK, they remarked, institutions are doing their own capacity building and occasionally including research fellows from the south – the major difference they saw with CHESAI was that the flow "is south to south, not south to north." They went on to remark that

"...in terms of the training and educational component, the students [CHESAI] has supported through this are all doing work which is really interesting. It's really cutting edge...and it's really useful. But the biggest impact – and this is what matters most for the African continent – is capacity building. Capacity is probably the biggest barrier to the problems that are here, and I'm amazed at how many students they've been able to support over the few years that they've been active."

Such an observation is noted as fundamentally significant because it gestures towards CHEPSAA's success in attempting to build up a "critical mass" of HPSR minded thinkers in the sphere of southern public health, and CHESAI's supplementary role in strengthening the networks around those efforts.

### 3.2 Environment

Several contributors spoke to the distinctive quality of environment created in CHESAI activities. For most participants, the mention of the retreats elicited a very positive response for their provision of a unique opportunity to simply write and to think, with no other obligations. Simultaneously, CHESAI acted as an effective gathering point for many in the field of HPSR; what can be thought of as the 'common room' effect [15]. This space was highly formative in terms of allowing new connections to emerge and fuse across disciplinary and institutional boundaries. The synergy of the environment was reflected across the board in our interviews. For instance, this kind of response from a non-South African CHESAI member was typical:

"I participated in meetings at UCT and UWC, interacted with MPH and PhD students at UCT, delivered an address...and participated in a CHESAI team retreat...during which I had numerous individual interactions with the researchers."

This, she contrasted with scholarship in her own country, where she reported that scholars are, by necessity, much more resource driven. There, there is simply less money and fewer people to afford

the “protected time” that CHESAI offers to scholars to stop and make horizontal connections with other people involved in other parts of the health system, not to mention time to write.

Another academic, based in a more traditional academic environment, was struck by the “refreshing” lack of hierarchy at CHESAI, and the attempt to distribute leadership amongst members. In attempting to flatten some of these power dynamics, CHESAI was seen as a forum in which it was possible to discuss research and methods in a much more candid way than she found possible elsewhere in her academic life. She felt as though there was greater opportunity for everyone to have a voice and therefore that the actual quality of the conversations being had at CHESAI were better than in other places. The search for answers seemed to come from the bottom up rather than the top down, and as a way of pursuing the goal of developing a voice from the South, she felt that all these things were important.

One last area pertaining to the CHESAI environment is deserving of comment, and this is the gratitude that many participants clearly felt in being invited to share a space with some of the most prominent people currently working within HPSR in Africa. One participant expressed that “both CHESAI and CHEPSAA [had] been an excellent platform” for their own personal development and that the lead drivers of the initiative “have really enlightened” the other members too. Thus one can say that for participants in CHESAI, it was the chance to interact with luminaries from the field in a collegial forum that formed part of the attraction. The fact that these relationships also entailed a form of mentorship cannot be underestimated, but we reserve further comment on this for the section of the report below, that speaks more directly to the idea of leadership.

### 3.3 Trans-nationality and the Global South

A concerted attempt to prioritize southern voices and southern networks is a hallmark of CHESAI’s approach. Certainly from the evaluation contributors, this was a recurring theme. For one, a strong southern HPSR network is precisely what he saw CHESAI helping to develop very effectively. There is so much cross-over in the issues facing countries from the Global South, that for him, transnational collaboration is the only sensible way to tackle similar health issues. Therefore CHESAI’s emphasis on building transnational southern networks was pivotal to its importance. He expressed, as common cause, that crossing national boundaries to tackle complex health issues meant building networks; indeed for him “there is no other way.” The advantage of CHESAI, over say global health conferences, which ostensibly deal with the same issues, is that CHESAI is a long term project and therefore allows important relationships to sediment and thicken.

Another contributor spoke positively about CHESAI helping to develop a voice from the South and opening the doors for collaboration. It has certainly helped to create a lasting linkage between health systems thinkers in West and Southern Africa, as is evidenced by the multiple collaborative conversations taking place between scholars from Ghana and South Africa itself. For a different contributor, they could point directly to CHESAI for helping to place them in touch with a health expert in the UK who has since gone on to co-supervise some of the work they are completing in South Africa.

A further participant spoke of the very tangible ways that CHESAI has helped her and her colleagues, and pointed without difficulty to concrete instances where it has helped to strengthen and deepen networks, build a southern voice and encourage a spirit of collaboration. In her words, “CHESAI is taking control of the evolution of the field” of HPSR in the south, and this can only be a good thing.

In short, CHESAI has clearly created the space and found suitable participants to initiate important and useful conversations concerning international health issues that would not have occurred

otherwise. However, it would be remiss to discuss CHESAI's unique environment without acknowledging the impact of CHESAI's permanent members in guiding debate and coordinating discussions. For example, one participant expressed explicitly gratitude at being able to learn from one of the organisers capacity for 'room management'; the frisson of excitement generated at Journal Club (as well as the fruitful interactions between practitioners and academics); and the extent to which leadership learning is emphasized in CHESAI activities. These outputs are necessarily difficult to quantify, but nonetheless extremely important to recognise. Seen from this point of view, it might be said that CHESAI has engaged in generating conditions for a particular form of collegiality around HPSR, the 'harder' outcomes of which will begin to be seen in the coming years.

Finally, and despite this explicit value base and location of itself within the politics of global health discourse, only one contributor framed the South emphasis as being part of an overtly (if not explicitly) political bent to CHESAI's work. She saw this in the questioning of what types of knowledge are valued in health systems thinking and in the common goal of a more equitable health system. She also felt that by deliberately incubating a southern voice (by specifically inviting speakers and experts from African countries and postdocs from the continent), CHESAI was making a political statement. For her, these all marked a specific attempt to be southern.

The trans nationality of CHESAI's approach and the opportunities this created is another of its distinctive features. Through its involvement with participants from India and Latin America, there has been significant reach, strengthening of relationships and cultivation of opportunities for collaboration in both HPSR scholarship and governance of the field. This has been accomplished largely through collaboration and the cultivation of mutually beneficial relationships.

From our interviews, it is clear that opportunities for researchers and practitioners to spend time in an academic environment alongside others from different countries and parts of the system are hugely appreciated. One contributor reported that there was no doubt how influential CHESAI had been on how she works, especially in her home environment. The area that CHESAI opens up, has allowed for lots of cross-learning and cross-fertilization across geographies and intellectual space. Another began by acknowledging that her time in CHEPSAA had offered valuable exposure to approaches from diverse others, but pointed out that this was taken much further in her CHESAI-supported time, in which she was supported to co-teach with others and to develop leadership experience by working with the Winter School curriculum, for future teaching in her home environment.

For these younger participants, CHESAI has not only helped them to strengthen their own networks, but has also been instrumental in supporting them to see themselves as playing an important role in advancing HPSR in their home environments. The ability of CHESAI to bring southern individuals and networks confidently into the global discourse, through global health symposia, is particularly noteworthy. Across the board, contributors were unequivocal about CHESAI's contribution to strengthening voices from the South. For one, as a young African women and new to the field, CHESAI was instrumental in giving her a platform to voice her ideas and a confidence to do so. She feels like she now has a "legitimacy," which she would not have had if it were not for CHESAI. She also feels as though through CHESAI, she has been able to embed herself as a serious contributor to the field of HPSR in the south and in the world, including becoming involved in structures promoting HPSR. Another told of similar experiences, including participating in a northern based academic programme with a sense of confidence and clarity of identity such that she felt she was not there only as a recipient of opportunity and knowledge, but also a contributor. She had a sense of coming from a 'home' out of which she could participate and contribute. In West Africa, publications by junior researchers are also on the rise. Whether this is linked directly to CHESAI or not is hard to prove, but it is happening nonetheless.

Indeed, the question of CHESAI's reach, extension and overall sustainability, was something that received substantial discussion too amongst the interviewees. It goes without saying that the capacity building element of CHESAI has been strongest in its work on the African continent. For some participants this has included exposure to and practice in CHESAI's content and methods for teaching HPSR. Additional exposure to opportunities like the Governance Workshop in 2016 offered a good example of the reason why they found CHESAI so useful. Apart from helping to stretch participants' understanding of governance the workshop was also typical of how CHESAI attempts to level hierarchies and keep an ear open to anybody with an interest in health subjects of collective mutual interest.

These opportunities and exposure also extended one contributor's PhD thinking: it gave her a "broader sense of how to explore [her] own research question" and also her work situation. As she said, "even though we are doing medical research, this angle of the social and political is helpful...these exposures inform my exploring of how politics and power inform decision making at national level." Exposure at Winter School gave her experience in this style, which made it easier to teach back home. The practical style of teaching she encountered at CHESAI was also a source of inspiration. For her, it was a way of teaching that enabled her to evoke her own personal experiences in the classroom: "when you compare it to traditional ways – of hard science – it is quite, quite different." For another contributor, CHESAI "allowed space to ask bigger questions." It encouraged for thinking through a "wider angle lens."

The CHESAI style of thinking and practice also seems to extend to the kind of student, or learner, being cultivated; students who are able to think across specialisations, across ordinary 'turf' and across geographical boundaries. One scholar reflected:

"compared to other types of student I have met, they are very lucky. They are in a project that allows them to learn collaboration while they are still students...I'm actually impressed to be honest. These are students [who are driving their own collaborative projects], and they are already aware of the tools of international collaboration...people are already talking about how to maintain these relationships, how to continue writing joint grants and so forth...the fact that we're already talking about next grant applications with students involved, is impressive for me."

This is reflected again in this statement from another contributor:

"...one of the areas that the project has been focusing on has been governance and leadership and it seems to me as [participants] have gone through that they've obviously been sensitized to those values. What the project has actually produced is a number of leaders going back to their countries to face the challenges of public health – and the field of public health is full of challenges."

However, the issue of creating new HPSR leaders in the South is not without its obstacles. For example, one of the contributors above was expressed concern about what will happen next for the postdocs who have been a part of CHESAI's story. For him, maintaining momentum and enthusiasm away from the overarching guidance of CHESAI's own leaders, might be the biggest challenge going forward. He couched his concerns in a vision of what a new iteration of CHESAI might look like.

"What I would like to see is CHESAI 2.0, but one that seeks to consolidate - because I see these issues popping up. CHESAI 2.0 would be asking, for instance, how [those returning to their home countries] do not fall through the net... [They] are going to be swallowed by the whole system there. I don't know exactly how CHESAI was originally set up to deal with this, but that is what I would say, were there going to be CHESAI 2.0."

He continued:



"The other thing that I'm worried about is that these systems that they're going back to....when they go back there they're going to have to fight to stay within the system – especially if the values and the practices that they've learnt here are do not 'dock' comfortably into whatever they find there. There is going to have to be some settling down to be done and some people give up. This is where I'm worried. There ought to be some support mechanism."

While these concerns seem well founded and wholly legitimate, we note that this type of support mechanism was not written into the initial CHESAI mandate, and the lack of provision should not therefore be seen as a shortfall on CHESAI's part. Rather, if CHESAI is indeed "a beautiful first step," as one participant noted, in the direction of HPSR in Africa, then a second step might well benefit from considering instrumental ways in which a network might be used to support health policy researchers once they are embedded in alternative health systems unfamiliar with HPSR.

### 3.4 Boundary-spanning - Networking across Disciplines and Institutions

Along with helping to develop a stronger voice from South, the ability and effectiveness of CHESAI to span boundaries and put different parts of the health system in conversation with each other is undoubtedly the resounding achievement of the initiative, and a facet which came up time and again for praise during feedback from participants. In the view of one contributor, there are two major reasons for CHESAI's success: firstly, it has immense academic credibility, and secondly, they have been instrumental in creating networks. Said participant's personal experience of CHESAI underpins his positive attitude, having met "tons" of useful contacts from an HPSR point of view and experienced the CHESAI space as one in which horizontal relationships were allowed to flourish. Extending reach through overlapping and intersecting networks creates multiple experiences and exposure within any single opportunity.

For the contributor, who in a period of three weeks, "participated in meetings at UCT and UWC, interacted with MPH and PhD students at UCT, delivered an address, and participated in a CHESAI team retreat," CHESAI and CHEPSAA both helped her to build up her network in HPSR on the continent, with contemporaries, health practitioners and more senior established academics who she would never normally have had access to. For another, the networked nature of CHESAI and the opportunities it provides for its participants was of obvious value: "...this course was very instrumental in shaping my PhD research proposal. [It] introduced me to the latest concepts being used in the field of HPSR, and also provided an opportunity for me to interact with students from South Africa, SADC Region, and the whole continent, including countries such as Kenya (East Africa) and Nigeria (West Africa)."

One of CHESAI's key 'spans' is its reach between academics and practitioners, despite their different paces of work, institutional locations and relationships to knowledge. For one (academic) contributor, while it might be simply too difficult for practitioners to leave their posts for extended periods and so enter the academic environment, and while CHESAI was essentially an academic initiative, a fundamental outcome has been that academics are being unequivocally trained to "cross the bridge" between policy research and implementation. This sentiment was reflected by both researchers and practitioners, and should therefore be understood as one of the key areas in which CHESAI has been instrumental in implementing HPSR. Indeed, it was neatly summed up by one academic participant as being "in the genes" of the initiative.

On the other hand, and in a clear show of mutual benefit, practitioner contributors to the evaluation expressed the direct and tangible benefit that participation in CHESAI activities gave to them. For one, this included being in collegial situations, both diverse and equal, in which diversity of views was encouraged. For this contributor, "collegial engagement around ideas" was the defining

characteristic of their CHESAI experience, which "made [them] think deeper about the issues" while simultaneously learning practical concepts and approaches with direct applicability to the field of practice [16].

In West Africa, CHESAI was instrumental in enabling networking, even within the region. This is an enduring contribution which these contributors are certain will persist even beyond the life of CHESAI. One contributor spoke in terms of "the networks fold[ing] in on each other." The contacts she has made through CHESAI, she will meet again in other guises throughout her professional career, and each time it will become an easier relationship, increasing its potential to blossom into something deeper, probably when necessity dictates. Therefore, in one important sense the seeds for transnational collaboration in HPSR are being sown by CHESAI, and this alone, is a crucial marker of success.

A different contributor focused on the relationship between CHESPAA and CHESAI, noting that CHESAI focuses particularly on networking beyond the classroom. She made the point that HPSR is specifically about networking, and "you can't network exclusively between teachers." In other words, for HPSR to be really effective and instrumental it has to expand out of research centres and create dialogue between all parts of the system. The bedrock, however, (the linkages and networks), is solid. Therefore, she did not fear that the ethos of CHESAI would recede, even if the name of CHESAI disappeared. For her, the networks engendered by CHESAI will inevitably reincarnate in other future forms, as the collaborations and networks are already in place and ready to adapt. In fact, might it almost be argued that phoenix-like, entities like CHESAI *must* die so that they can re-emerge and reconfigure in ways that push new leadership to the fore, keeping everybody fresh and reducing the risk of burnout.

Another networking example is offered by the relationship between UCT and UWC. One younger contributor contrasted the conversations enabled by CHESAI with the conversations she would (or rather wouldn't) be having in a clinical setting. Further insight into the networking capabilities of CHESAI is offered in a joint reflection on experience from the CHESAI post-docs in 2016 [17], who have written extensively about their experiences in a co-authored paper:

"A unique feature that we found in the CHESAI Postdoctoral Research Fellowship was its embeddedness in the community of practice. The CHESAI team is highly involved in collaborative projects at various levels of the health system. This created an opportunity for us to engage with practitioners and understand the practical application of HPRS and how to influence policy. This experience exposed us to a better understanding on how to engage with practitioners in a meaningful and productive manner. The co-production approach between researchers and practitioners is very powerful in HPSR, as it ensures better uptake of research findings"

A focal point for CHESAI's boundary and institution spanning was clearly the Western Cape HPSR Journal Club, which deserves special mention here as it kindled enthusiasm in all of the participants we interviewed.

For one practitioner, the content of the Journal Club meetings; choice of topics; and the space created for reflection and conversation, as an "opportunity for personal and professional development" felt essential to the development of their understanding of contemporary South African health issues. Further, the emphasis on ideas, the strong thread of systems thinking and deep working understanding of concepts that become common to other participants were seen as instrumental in enabling practical application of HPSR approaches within a working health system.

For one senior policy maker, useful working concepts have emerged directly from their collaboration with CHESAI, particularly through the Journal Club. These include an approach to "systems thinking," "leadership of place," and "boundary spanning" which have since come to feature prominently in

their work over the years. One session on policy implementation in 2014 was cited for being especially "useful in dealing with internal and external governance." What is more, these concepts have evidently filtered into the departmental frameworks of health practitioners, so that they are gaining real purchase within parts of the health system that have not even come into direct contact with CHESAI.

For example, a Journal Club paper on system failure was reported as being "one of the most useful readings, as we drew extensively on it for our "systems thinking discussion document." More recent work on community engagement and a very powerful session on 'systems resilience' has been incorporated into departmental policy. Herein is further evidence of how HPSR concepts, which originate in CHESAI forums, have "mushroomed across" departments of health which are ostensibly unconnected to CHESAI at all. This is noted as a very significant and beneficial repercussion of Journal Club for practitioners and the health system as a whole.

Another practitioner engaged in system management found the diversity of opinion in Journal Club most refreshing. Applied topics like working in a 'values-led' way and seeing the connections between maternal mental health and other parts of the system were especially valuable to her. Moreover, CHESAI's emphasis on horizontal networking inspired her to infuse her collegial relationships, ordinarily characterised by strong hierarchical lines and formal modes of relating, into something resembling a space of mutuality, respect and enquiry.

As CHESAI comes to the end of this funding cycle, a further important outcome is worthy of note; that of practice speaking 'back' to scholarship. This is one of the critical outcomes of CHESAI's boundary spanning approach, and one that has been especially facilitated by Journal Club. In the forthcoming Vancouver HPSR conference, three senior officials and members of Journal Club will attend. Preparation and submission of the contribution was finalized months ago, but in the view of one of the officials, so much has happened since then – that the world of policy and practice moves way faster than does scholarship – it is not altogether clear to him whether their contribution will still be relevant. This raises an important point. If the pace of health practice is so much faster than the pace of health research, how can this gap be narrowed so as to make health policy research and health policy practice more symbiotic? This would appear to be an important consideration not only for CHESAI, but also for the broader field of HPSR in general. For at least one contributor, the Vancouver conference presents an opportunity to raise these questions about the relevance of academia to practice, and to speak to the necessity of up to date knowledge from the point of view of the system itself.

Some CHESAI participants are both researchers and practitioners and for them especially, CHESAI's practical approach to teaching and research, including participatory methods, action research and in-depth case studies enabled fluid and natural transitions between academic and health institution environments. These methods were seen to be "most appropriate" and "most suitable" to the realities health systems, and therefore, most relevant to meeting the needs of students who wish to make meaningful contributions to these institutions.

Overall, Journal Club has immense value for everyone involved. On the side of the researchers, it is through correspondence and interaction around Journal Club, [that] the relationships [between researchers and practitioners] grow." Amongst practitioners, it is exposure to "the same concepts and conversations have been happening amongst the same people that strengthens them," and therefore cements them in departmental practice, as seen above. This is true for practitioners within institutions and also those across public health institutions, where ordinary institutional cooperation has been smoothed and strengthened through common experience of Journal Club.

Given the unqualified success of Journal Club in its ability to flatten some of the excesses of hierarchy, to disseminate relevant ideas and to support practitioners to build purposive relationships with researchers, it might be asked whether it can be expanded or replicated, without diluting the trust and collegiality of the current form. To this, one contributor said "I have invited many people along, but many have not continued to attend, for various reasons, mainly to do with the time of the meeting and venue, as many have school-going children with set responsibilities after work hours. We have created many similar informal spaces within the Department (for Departmental employees), to engage in similar "thinking spaces".




Another contributor shared a similar perspective and spoke of attempts to run similar fora within working hours. Whether these attempts will work or not remains to be seen, and whether they can sustain themselves without the instrumental leadership of both the academics and the senior officials also remains to be seen. However, that the space is considered sufficiently valuable to merit trying various alternative forms is another indication of the success of the space.

Ultimately, CHESAI's broad success in the above categories is very apparent, and perhaps best summed up by the fact that one of the visiting experts was moved to admit, with undisguised admiration, his (good humoured) envy about CHESAI's work and his desire to replicate something similar in his home region. Instead, he sees the health institutions where he is from working broadly in isolation, with little attempt made to put them in conversation with one another.

### 3.5 CHESAI Tracing Relationships, Ideas and Practices- a graphic analysis

One way of seeing CHESAI's outcomes, and potential long term impact that it has contributed to, is to see it as a set of nested circles, with more immediate and quantifiable activities and numbers of people reached translating into a characteristic and identifiable quality in relational outcomes, which in turn has contributed to recognizable prominence of certain ideas, scholarship and practices within the field of HPSR. These are represented graphic form in a separate document.

**CHESAI: COLLABORATION FOR HEALTH SYSTEMS ANALYSIS AND INNOVATION**  
**2012 – 2016 | TRACING RELATIONSHIPS, IDEAS AND PRACTICES**

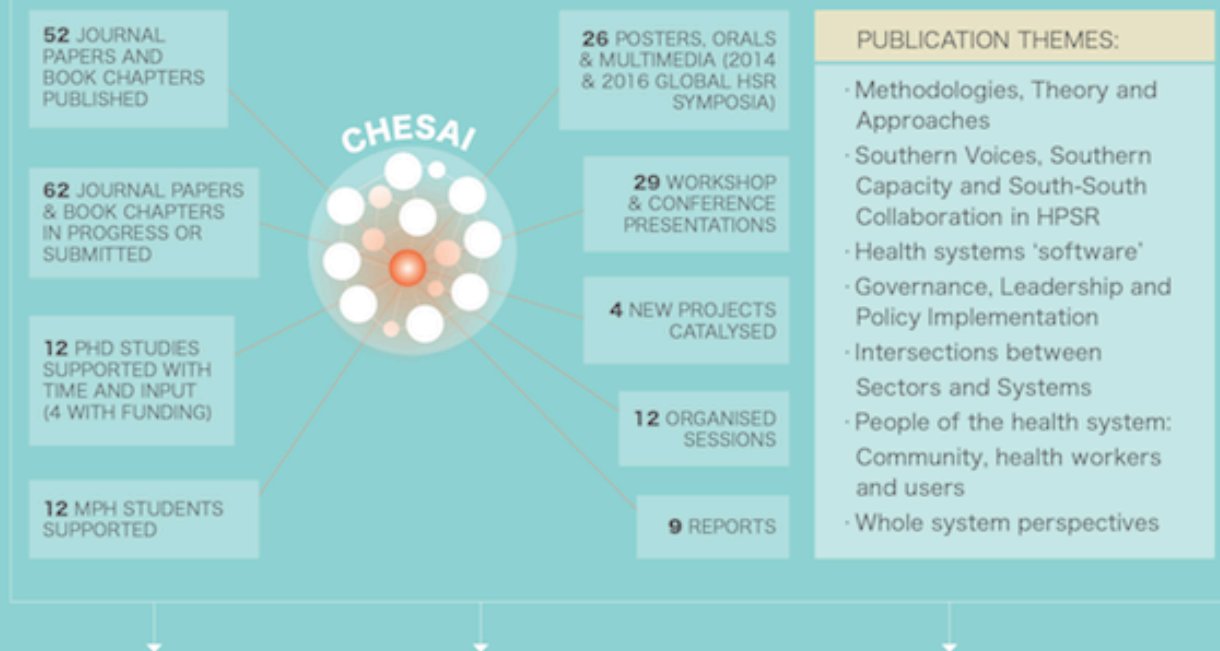
WESTERN CAPE	ACADEMIC HUB: UCT/UWC	WC HPSR JOURNAL CLUB	MPH BURSARIES
	Local community up to 20 scholars into which the broader CHESAI network enters and associates; from which it returns home	Regular group of senior dept of health managers, CHESAI scholars & other researchers (10 - 15)	12 Public Health Master's students bursaries, supporting them to develop thesis topics
RELATIONAL OUTCOMES	<ul style="list-style-type: none"><li>- Collegiality &amp; collaboration in &amp; between institutions &amp; modelling of this for those who enter from other contexts</li><li>- Greater collegiality &amp; commonality of approach within the health system</li></ul>	<ul style="list-style-type: none"><li>- Collegiality &amp; collaboration between academic hub &amp; the public health system</li><li>- Greater collegiality &amp; commonality of approach within the health system</li></ul>	<ul style="list-style-type: none"><li>- Greater familiarity with teachers and scholars in the CHESAI hub</li></ul>
IDEAS, SCHOLARSHIP AND PRACTICE	<ul style="list-style-type: none"><li>- Cross fertilisation of ideas, disciplines &amp; methods; greater research collaboration in and between institutions; increased interest in and dexterity in working with 'cross-cutting' themes in health systems research (eg: values, leadership)</li><li>- Greater collaboration in &amp; between institutions on research initiatives</li><li>- Increased interest &amp; dexterity in cross-cutting themes in public health</li></ul>	<ul style="list-style-type: none"><li>- WC DoH policy: systems thinking, relationships, resilience, leadership</li><li>- For academics: grounded grasp of the realities of public health systems &amp; interest in developing more responsive methods &amp; approaches</li></ul>	<ul style="list-style-type: none"><li>- Students whose early specialism has been guided to this approach to HPSR</li></ul>
AFRICA	POSTDOCS	RESEARCHERS AND ACADEMICS	PUBLIC HEALTH PRACTITIONERS
	4 postdocs from DRC, Botswana, Ghana, Malawi - scholars with a close connection to policy and practice of public health systems in their home environments	49 researchers, academics and public health practitioners from SA and other African countries on Winter School Bursaries, and 6 South African practitioners located at a SoPH for periods of research and engagement	
RELATIONAL OUTCOMES	<ul style="list-style-type: none"><li>- Reaching and supporting scholars to work in African institutions – with academic, policy and practice reach; greater exposure and access to one another &amp; to Global HPSR</li></ul>	<ul style="list-style-type: none"><li>- Connection with the CHESAI hub and one another</li></ul>	<ul style="list-style-type: none"><li>- Greater familiarity with academic contexts and researchers</li></ul>
IDEAS, SCHOLARSHIP AND PRACTICE	<ul style="list-style-type: none"><li>- Greater exposure to HPSR, consolidation of concepts from a Southern context; 'cross-cutting' themes in health systems research; collaborative and collegial modes of working as part of academic practice</li></ul>	<ul style="list-style-type: none"><li>- Exposure to and mentoring in HPSR curriculum and approach to teaching for application in other teaching environments; increased interest and dexterity in 'cross-cutting' themes in health systems research</li></ul>	<ul style="list-style-type: none"><li>- Practitioners: exposure to HPSR concepts &amp; practice, including cross cutting themes in health systems research &amp; motivation to apply these in policy &amp; practice</li><li>- Academics: grounded grasp of the realities of public health systems &amp; interest in developing more responsive methods &amp; approaches.</li></ul>
GLOBAL SOUTH	EXPERT RESIDENTS		
	4 expert residents - from Ghana, India, Argentina and Zambia. Established scholars who also pioneer and drive institutions, networks and HPSR initiatives in their own contexts		
RELATIONAL OUTCOMES	Growing collegiality and trust amongst Southern experts who both contribute to and draw from CHESAI's Southern and global reach, deepening the institutions and networks that pursue a systemic approach to HPSR; ever stronger Southern collegiality & collaboration globally & institutionally.		
IDEAS, SCHOLARSHIP AND PRACTICE	Shared scholarship, co-publication by Southern experts; Southern leadership of institutions & initiatives dedicated to pursuing HPSR; contribution to a growing understanding of what these contexts both ask of & offer to the practice. Distribution & use of materials across the network		

**CHESAI: COLLABORATION FOR HEALTH SYSTEMS ANALYSIS AND INNOVATION**  
 2012 – 2016 | **CONTRIBUTING TO EXPANDING, TRANSFORMING & DEEPENING HPSR**

**CHESAI'S CONTRIBUTION TO GLOBAL HPSR – IDEAS, SCHOLARSHIP AND PRACTICE:**

Systemic and cross cutting emphasis in HPSR; research grounded in institutional realities; teaching materials and practice; collaboration as a mode of work; scholarly production.

**CONTRIBUTION TO SCHOLARLY PRODUCTION THROUGH OFFERING TIME AND SPACE, ENABLING COLLEGIAL ACCESS AND COLLABORATION**



ONLINE REACH	NEW WEBSITE (in 5 months)	DOWNLOADS OF COURSE MATERIAL (From CHEPSAA website, via CHESAI page)
13 publications, selected for diversity of themes and authorship, tracked: <b>28 868</b> downloads <b>109</b> citations <b>135</b> tweeters	<b>1419</b> users (20% SA, 20% UK, 10% Kenya) <b>3491</b> page-views <b>77%</b> returning visitors	<b>56</b> countries in 18 months INTRODUCTION TO COMPLEX HEALTH SYSTEMS: <b>296</b> times (minimum) INTRODUCTION TO HEALTH POLICY AND SYSTEMS RESEARCH: <b>249</b> times (minimum) UNDERSTANDING HEALTH POLICY: <b>414</b> times (minimum)

## **4. Critical perspectives**

In this segment of the evaluation, we append some final thoughts on CHESAI's successes and possible areas for future growth. Over and above the categories discussed in the previous section, four critical perspectives emerged from our engagement with CHESAI people and materials.

### **4.1 A Question of Interdisciplinarity and Inclusivity**

As alluded to above, CHESAI faces a potential paradox inherent in attempting to create an interdisciplinary space that aims to be inclusive of a multiplicity of perspectives. In working to create a strongly identified HPSR community, there is naturally a risk of inviting tension between 'insiders,' and 'outsiders.'

This tension emerged in the mid-term evaluation, especially in relation to the Journal Club, where there was some acknowledged risk of Journal Club becoming a space for 'insiders' to a systems perspective, rather than it being one manifestation of such a perspective, that by definition was then inclusive of all perspectives (including those that saw health systems as linear and static). In the UCT/UWC hub, a similar concern emerged, not as tension within the hub, but as a concern (and conceptual puzzle) as to how to be inclusive of (and interdisciplinary *with*) approaches and disciplines that were exclusive and proudly specialized, and therefore not disposed inside of themselves towards boundary spanning interdisciplinarity.

One contributor also flagged a concern that CHESAI might consider clinicians more deliberately in its future thinking and practice. She saw a danger of Public Health becoming bifurcated once more (with systems focused social scientists splitting off from single issue-oriented, quantitative and/or clinical people). Whilst CHESAI might be seen to challenge this head on (by training medics in social science methods), there is the risk that CHESAI isolates those not already convinced by an HPSR approach. This could result in CHESAI developing in parallel to other programmes and not joining up with them. For the contributor above, there was also a question of who from the universities is welcome to attend Journal Club, and how they gain access to it. A concern for her, therefore, was whether CHESAI could attract a diverse enough spread of academics and practitioners, or whether it was limited by only attracting people who were already deeply invested in an HPSR approach to public health. Whether this represents a 'problem' or not is certainly up for debate, but is nonetheless worth noting.

Continuing on the theme of interdisciplinarity, it was noted early on in CHESAI's ToC that "there are core differences between paradigms of knowledge, and on how to approach interdisciplinary work" [18], and therefore a clear appreciation of the complexities involved in breaking traditional academic knowledge 'silos' and inculcating new ways to approach problem solving that transcend disciplinary boundaries. Earlier in the evaluation, we noted that CHESAI has intentionally and successfully created a space that supports and encourages researchers to work across their disciplinary comfort zones. However, it seems worth asking how much further CHESAI's approach to interdisciplinarity or 'transdisciplinarity' could be taken? Just as it has been noted that HPSR is subject to scrutiny for its "fuzzy boundaries" (Gilson 2012), so interdisciplinarity too is a term that risks hiding more than it reveals.

Thus, a suggestion moving forwards is that CHESAI defines more explicitly its interdisciplinary aims and aspirations. To be sure, in the feedback was plenty to suggest that the CHESAI environment was expansive and receptive to multiple points of view. However, the concept of inter or transdisciplinarity can have much further potential than bringing different disciplinary voices to the table. For instance, it can suggest ways to create brand new amalgamations of knowledge and fresh

intersections between unexpected spheres of influence (see Max-Neef 2005). Due to the general ambiguity over what interdisciplinarity entails, it is unclear precisely what kind of interdisciplinarity CHESAI has tried to articulate, and therefore how successful it has been on that front. Feedback from participants did suggest that the practices could be more interdisciplinary than they are. One contributor felt as though CHESAI, while open, could certainly benefit by incorporating a wider field of disciplinary backgrounds.

Again, this is not to suggest that there is not interest in topics that cut *across* traditional silos and speak to the very human and systemic nature of public health institutions and their functioning, or to deny that this interest cuts across academics and practitioners, with common language and concepts being used by both in describing the approach, but simply to say there are alternative ways of engaging an interdisciplinarity which the organisers of CHESAI may want to consider.

Thus, while it is true to say that the ground has certainly been prepared for interdisciplinary work to take place – notably through the egalitarian, inclusive and engaged style of exchange and enquiry and the interactive and experiential approach to teaching - it is not yet clear exactly what interdisciplinary work is taking place, beyond the *de facto* multidisciplinary nature of public health. A clearer articulation of interdisciplinary intention in CHESAI's ToC would help to clarify most, if not all the issues referred to above. This might include, whether in policy making or research, a recognition of the importance of working relationally and being guided by explicit values and goals. Researchers whose topics have been informed by this way of seeing acknowledge the significance of this choice, for example, one said "I focused on one topic, but it was as a case study into how things were done across the whole system." This does indeed place the CHESAI emphasis apart from other social science approaches to public health, including health economics, and certainly from epidemiological approaches, which tend to prioritise more linear and less context specific solutions to health problems. As discussed earlier in the report, to the extent that this HPSR sensibility takes hold, it certainly entails a different way of seeing, generating policy, managing, and researching public health systems.

#### 4.2 A Question of Articulation and Ambivalence

Another critical element which emerged during a number of interviews was the sense that CHESAI, despite its remit to implement HPSR in South Africa and beyond, can occasionally seem somewhat "fluffy." Several, while appreciative of the opportunities generated by CHESAI, were reluctant to attribute any major contributory power to these opportunities, for any accomplishments or projects.

One possible reason for this sense of ambiguity amongst participants is that CHESAI's loose nature can be double-edged. Participation in CHESAI's processes, and freedom to contribute to these can leave some feeling uncertain and in need of greater direction and clarity. Herein lies another systemic tension. Whilst reducing hierarchy and creating an egalitarian, intercollegiate environment, the hands-off nature of leadership can also be potentially unsettling.

The same ambivalence is also pertinent when it comes to leadership. On the one hand, the current leadership is pivotal for holding the space and driving the conversations within CHESAI, and is highly valued. On the other hand, there is a recognition that more diverse leadership would lead to more diverse discussions. Yet how to segue to this – for all: both leadership and others – is a persistent and pressing question, for CHESAI and for any similar initiatives into the future.

Ambivalence is a quality that cuts also into reflections about how it was to lead CHESAI. The enormous effort required to galvanize participation in CHESAI opportunities was a repeated reflection throughout the evaluation. Initially this was so for almost all of the CHESAI activities



where, by the mid-term evaluation, only the hub and the Journal Club were fully up and running. By the final evaluation, things had changed significantly, and the various CHESAI opportunities, including postdocs, visiting experts and Winter School bursaries were well used. Yet still, and at the heart of things, some difficulty in galvanizing whole-hearted engagement in CHESAI and its potential for co-ownership of the initiative and its potential, remained.

Out of this, the questions that come to mind are: are the CHESAI leaders being adequately acknowledged and supported while they draw on their immense personal skills and resources? Is this sort of leadership knowledge transferable to others in their groups? And how could this experience of leadership as both *herding* (from behind) and path-breaking (from the front) help other groups attempting to undertake similar efforts?

#### 4.3 A question of Longevity of Intention

Contributors considered the question of CHESAI's own longevity, and also the longevity of similar such initiatives. For one, "... it is hard to put value on the contribution of a PhD or a master's student. We cannot know what their future contribution will be. But if there were ever to be CHESAI 2.0, it would be good for it have a foothold in other countries too." With regard to CHESAI's potential for replicability, this contributor saw CHESAI as "a beautiful first step" towards building HPSR in the global south. The challenge was to keep the spirit of CHESAI and make it replicable on other continents.

Another was sanguine about CHESAI coming to the end of its cycle, and not because she didn't think it was of value. She spoke about the convention of 2-5 year funding cycles and the limit that this automatically placed on an initiative like CHESAI. Thus, she felt certain that beyond this, a new version of CHESAI or something like CHESAI would inevitably emerge to pick up the baton and continue driving in the same direction. She referred to this as the "shifting sand of acronyms," which is bound to change over time.

On the other hand, another asked "How are we going to prevent the leaders we are training from moving to different places on the globe if there's no support mechanism? So does CHESAI have a policy for support? Is it possible to stay on with CHESAI?" In a context of globalisation, this is an understandable concern, while certainly not resolvable through the efforts of any single project. Yet it does suggest to CHESAI, and related initiatives that consideration is given to their methods such that the reality of the global 'pull' is taken into account.

Looking at this caution, some interesting observations arise: for some contributors, their experience of CHESAI has opened a vision for what might be possible in inter-disciplinary research, or at least a systems view of research, and even trans-disciplinary research, between practitioners and scholars. Thus while they may feel the pull of global, they will take with them this particular focus and angle on things – itself an accomplishment for CHESAI. For others, there is the hint of an emerging and very particular sense of identity – and some confidence – in relating to the global stage not just as southern recipients of capacity and input, but also as contributors to a transforming global discourse. This is true for academics and also practitioners, as evidenced in the experience of practitioners going to Vancouver asking what are the ways in which knowledge can be made that can better reflect the realities – and keep up with contemporary realities – of institutional life? While Vancouver is an opportunity to reverse the typical dynamic (of knowledge being passed to practitioners), there is still the challenge of relevance. How can practice better influence and drive the academic agenda?

Seen in these ways, CHESAI's contribution, while nascent, may well be not simply to feed more bodies into the southern and global pool of HPSR, but actually support emergence of people who might make new, formative and challenging contributions to it. Of course, the source of this inspiration is itself global, in that the leadership of CHESAI have themselves emerged out of a global accomplishment. But they have chosen to make their contribution in very particular ways that intervenes into the system of HPSR, allowing new, and potentially disruptive voices and dynamics to emerge.

Another area of contention which emerged from the evaluation was fear about the transferability of CHESAI's ethos to other contexts on the continent. For instance, once the postdocs find themselves outside of the incredibly supportive hub in Cape Town, where CHESAI is located, will their commitment to systems thinking and HPSR in general be able to gain traction? When asked about this, one contributor, speaking from his own experience of completing training programmes abroad, said he feared that the postdocs' colleagues in their home countries might deride the insights which they had gained at CHESAI: "they want to make the newcomers feel bad, to say 'who are you? You've been away so many years and now you're going to tell us how it's going to be?' He went on, "if they swagger into that environment they're going to be put down."

This sentiment deserves serious engagement - not because it represents a failure on CHESAI's side (a supportive infrastructure for leaving postgraduates was never a part of CHESAI's ToC) - but because any further iteration of CHESAI's ToC might wish to think about how to support postdoc fellows beyond their involvement in the Research Fellowship, for example the suggestion to have more transnational comparative conversations regarding various health systems in Africa and the rest of the Global South.

## **5. Conclusion**

CHESAI seeks to advance social science methods in HPSR, which has, so far, been more strongly influenced by, for example, epidemiology and health economics. This approach foregrounds the interconnected, systemic and therefore relational character of health systems which leads to an emphasis on interdisciplinarity, collegiality and having a systems perspective in policy making and practice. CHESAI also mirrors this approach in how it goes about its work.

This has generated a new, contemporary form of organisation for collegiality, exchange and knowledge production within the field of HPSR - a contemporary "common room" that spans boundaries of discipline, institution, and place - and reaches across the divide between academia and practice. In addition to the increasingly coherent and resilient Southern voice within HPSR that this approach has contributed to generating, it is also showing outcomes in the way in which knowledge is generated, and in the very nature of that knowledge.

Through taking enquiry to the place of experience, through conducting such enquiry in the medium of sustained relationships, and through maintaining a resolute openness to and interest in broad based approaches, CHESAI has supported and contributed to the generation of new knowledge that presents fresh angles on health systems research, and refined insights into how these systems work, simultaneously increasing relevance and accessibility of knowledge, offering benefit to both practice and academia.

This boundary spanning between health systems and academia, and the relative ease of access it offers both practitioners and scholars to one another, might be an especially distinctive Southern experience. Given this, the fact that CHESAI is contributing to emergence of scholarship practice and outcomes that are embedded in, and directly relevant to the Southern context, is a further

accomplishment. In the future, and as the field emerges, it may be that CHESAI has been a player in enabling Southern experience and realities to not only access the global field of HPSR, but to shape it in terms of those experiences and realities.

The field of network building is relatively new, as is interest in it from both the perspectives of organisational theory and programme effectiveness (including the question of value for money). Working intentionally through the medium of collegial relationship, with all of its diffuse and intangible effects and qualities is both innovative and risky, and a real test of the systems insight that relationships do matter. One of CHESAI's key challenges has been to show concrete outcomes, not just in 'improved relationships' but also in changed, increased and improved scholarship. Clearly this has taken the time that it was given – a shorter period might not have yielded the results that are seen in this evaluation. However, and at this point, it is clear that CHESAI has contributed directly to the emergence of a significant and astonishingly plentiful scholarship. This includes knowledge 'products', discourse and ideas and practices suitable to this field, all achieved through collegiality in its various forms. Given the outcomes and impacts that this evaluation has traced, we are confident that a cost-benefit analysis would bear this claim out.

While the funded period of CHESAI is drawing to a close, the relationships, ideas, practices and productive scholarship that it has supported persists, as do new forms of 'collaboration for health systems analysis and innovation,' both formal and informal. As these continued collaborations manifest into the future, it bears considering how they might address the challenges posed out of this evaluation.

How does one work in a way that is both socially and conceptually inclusive, yet also distinct – making room for all disciplines in the system while still creating a distinctive identity for health policy and systems research? The challenge of inter and even transdisciplinarity. In this regard, the drivers and participants in CHESAI are well placed to take this process of conceptual and practical definition further still, in both individual and collective pursuits.

As this definition continues to grow, as the field becomes increasingly apparent and distinctive, and as scholars are increasingly drawn to the approach, new leaders and drivers of the work will emerge. While the pioneering phase of CHESAI, both organizationally and conceptually, has required strong leadership from the centre, the next period is seeking to support leadership in centres other than Cape Town, and by people other than CHESAI's original founders and central circle.

This devolution of initiative will ask of those associated with CHESAI, including its donors, that new eyes are cast on the field to see the new opportunities and needs that present. This will surely include continued provision for networking and sustained collegiality. One of the insights of this evaluation has been how CHESAI has held spaces for collegiality that, through 'ordinary' budget cuts, and also through the increasingly networked and global nature of academic practice, were becoming smaller and smaller. The contemporary 'common room' of retreats, bi-monthly meetings, Journal Club, opportunities for informal exchange and structured mentoring, access to innovative courses, visits and residencies ... all of these forms merit continued support if the accomplishments of CHESAI are anything to go by.

In addition, and partly as a result of the success of these forms, we can anticipate new manifestations of this approach within the Southern context. These might be variations on CHESAI, as suggested above, from both the Western Cape hub and also emerging out of other places. They might also include more structured manifestations of the impulse that CHESAI has nurtured so ably, including perhaps the emergence of new institutions and positions that advance scholarship in this approach to HPSR. This will represent a developmental progression of the CHESAI impulse and, if

supported by donors, affirmation and continuation of the 'return' on the original CHESAI investment, and a significant contribution to scholarship building around HPSR, especially in the South.

### **List of Internal Documents**

- [1] See Appendix A for full Terms of Reference
- [2] See Appendix B – Evaluation activities
- [3] First CHESAI proposal
- [4] Ibid, (Frenck 2010, quoted p3)
- [5] Ibid, p2
- [6] Ibid (AHPSR 2004, quoted p11)
- [7] Ibid
- [8] Ibid
- [9] Ibid, p14-15
- [10] Ibid
- [11] Ibid
- [12] First narrative report to donors, 2012
- [13] Ibid
- [14] Kabir reflection
- [15] Narrative report to donors
- [16] Resilience, Mental Health, community engagement, working collegially and from a value base, HSS
- [17] Post doc reflection
- [18] CHESAI retreat report 2012, p2

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